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Office of Administrative Law Judges
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Issue Date: 09 January 2003

Case No.: 2001-BLA-0234

In the Matter of
PANSY PRATER HOPKINS, Widow of
MARVIN HOPKINS (Deceased)
Claimant,

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
Bill Moseley, Esq.
Pikeville, Kentucky
For the Claimant

Anne T. Knauff, Esq.
Nashville, Tennessee
For the Director

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER
DENYING WIDOW'S BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, (hereinafter referred to as "the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

[1] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80,045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

Issues

The issues in this case are:

1. Whether the Miner had pneumoconiosis as defined by the Act;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment; and

3. Whether the Miner's death was due to pneumoconiosis.

(DX 31; Tr. 8).[2]

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

Findings of Fact

Procedural History

Mr. Marvin Hopkins ("Miner") filed a claim for black lung benefits on March 25, 1983. (DX 30). His claim was denied on February 7, 1985, after it was determined that Mr. Hopkins did not establish any element of entitlement. (DX 30). Mr. Hopkins died in 1997, and on December 30, 1999, Pansy Prater Hopkins ("Claimant") filed a claim for widow's benefits. (DX 1). The claim was denied on April 10, 2000, and again on August 22, 2000. (DX 21, 29). Mrs. Hopkins made timely requests for a hearing on May 1, 2000, and August 28, 2000, and the case was transferred to this office on November 28, 2000. (DX 22, 27, 31). A formal hearing was held on May 22, 2002, in Pikeville, Kentucky.

Background

Marvin Hopkins was born on July 23, 1922, and he died on January 2, 1997. (DX 1, 8, Tr. 10). Mr. and Mrs. Hopkins were married on October 17, 1942, and they remained married until Mr. Hopkins died in 1997. (DX 7, Tr. 10). Mr. Hopkins never smoked cigarettes. (Tr. 16).

Length of Coal Mine Employment

Mr. Hopkins was a coal miner within the meaning of § 402(d) of the Act and § 725.202 of the regulations. The parties stipulated and I find that he had at least 28 years of qualifying coal mine employment. (DX 29, 31).

[2] In this decision, "DX" refers to the Director's Exhibits, and "Tr." refers to the official transcript of the May 22, 2002 hearing.

Medical Evidence

The record contains x-ray readings, pulmonary function and blood gas studies, which are detailed below. Chest x-rays which were not read for the purpose of classifying pneumoconiosis will not be detailed herein.

Chest X-rays

Ex. No.	Date of X-ray	Physician/Qualifications	Impression
DX 13, 30	7/12/73	Odom	1/1 p
DX 30	2/07/83	Cole B[3] BCR[4]	U/R
DX 12, 30	2/07/83	Brandon B BCR	p 1/1
DX 16, 30	2/07/83	Meyers	1/1 p/q
DX 30	2/16/83	Cole B BCR	0/0
DX 30	2/16/83	Anderson	Category I pneumo
DX 30	3/08/83	Cole B BCR	0/0
DX 30	3/08/83	Penman	1/1 p
DX 30	4/25/83	Cole B BCR	negative; film quality 3
DX 30	4/25/83	White BCR	negative

[3]A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

[4]A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

A letter from Joseph Lamonica, Chief of the Division of Health, Coal Mine Safety and Health Administration, dated February 26, 1979 advised the Miner that a chest x-ray had been read positive for pneumoconiosis. (DX 14). The letter does not indicate who read the x-ray.

Pulmonary Function Studies

Ex. No.	Date	Physician	Height/Age	FEV1	FVC	MVV
DX 13, 30	7/12/73	Odom	69/51	2.80	3.80	83.6
DX 16, 30	2/07/83	Myers	69.5/60	1.40	2.61	76
DX 30	2/16/83	Anderson	69.25/60	2.15	2.95	87.13
DX 10, 30	3/08/83	Penman	69/60	2.16	2.72	73
DX 30	4/25/83	Arnett	60/68.5	2.22	2.86	108
		Post-bronchodilator		2.12	2.98	114

Blood Gas Studies[5]

Ex. No.	Date	Physician	PCO2	PO2
DX 11, 30	2/16/83	Anderson	41.8	81.3
DX 30	4/25/83	Arnett	41.8	84.7

Narrative Medical Evidence

In a letter dated July 12, 1973, Dr. P.L. Odom stated that the Miner had worked twenty-six years inside coal mines as a joy man and motorman. (DX 13). Dr. Odom reported Miner's complaints of shortness of breath upon exertion. He classified a chest x-ray as positive for pneumoconiosis.

The record contains hospital records, some of which are handwritten and illegible. (DX 18-20, 25). Miner was hospitalized on July 12, 1982, suffering from right posterior chest wall pain. (DX 15, 19) Dr. R.V. Mettu found a right lower lobe mass on chest x-ray, which he concluded was most likely bacterial pneumonia. In the discharge report, dated July 23, 1982, Dr. Stamper diagnosed (1) right lower lung masses; (2) chronic obstructive pulmonary disease; and (3) diabetes mellitus.

[5]Blood gas studies taken during the Miner's hospitalizations, and which do not comply with the requirements of 20 C.F.R. Section 718.105 will not be detailed herein.

In a hospital discharge report from August of 1982, Dr. Charles E. Martin recorded that Miner was hospitalized and underwent a brochoscopy, mediastinoscopy, right limited anterior thoractomy and biopsy of mass in right lower lobe of lung. (DX 19, 30). The biopsy of the right lower lobe of the lung revealed blastomycosis. Drs. Paul Young and David Dahlenburg found the lung to have extensive acute inflamation present and fibrosis. (DX 19). The microscopic diagnosis included abscess in peripheral portion of lung containing budding yeast. The morphology of the yeast was found to be compatible with Blastomyces species. The lymph node was found to have anthracotic pigmentation and histiocytic proliferation. The microscopic diagnosis included anthracotic lymph node, and a finding that the lung had extensive acute inflamation present and fibrosis.

Dr. John E. Myers submitted his findings regarding the Miner in a report dated February 7, 1983. (DX 16, 30). He recorded a coal mine employment history of thirty-five years, twenty-eight years of which was underground. Dr. Meyers noted that Miner is presently quite short of breath, and that Miner complained of exertional dyspnea, cough with sputum production, and difficulty sleeping. Miner also complained of wheezing and chest pain due to his lungs. Dr. Meyers detected distant breath sounds and impaired air exchange upon physical examination. He performed a chest x-ray, electrocardiogram, and a PFT. Dr. Meyers interpreted the PFT to reveal a severe restrictive defect, and he interpreted the x-ray as positive for pneumoconiosis. He opined that Miner would meet the criteria for disability under part 718, Appendix B insofar as his ventilation studies are concerned. Dr. Meyers attributed Miner's pulmonary condition to Miner's blastomycosis, his old rib fractures, his surgery, and silicosis combined. He also found that Miner's silicosis results from Miner's underground coal mining employment. Dr. Myers listed the following diagnoses at the outset of his report: (1) pulmonary blastomycosis; (2) radiographic findings compatible with coal worker's pneumoconiosis, Category 1/1 p/q; (3) the above two associated with rather marked restrictive and mild obstructive defects in ventilation, functional class III; and (4) diabetes mellitus, insulin dependent. Dr. Myers suggested that verification of the Miner's silicosis might well be obtained by reexamination of the biopsy material taken at surgery when his blastomycotic lesion was removed. Dr. Meyers also noted that Miner's pulmonary condition prevents arduous manual labor, and restricts normal physical activity.

Dr. William H. Anderson examined the Miner on February 16, 1983. (DX 11, 30). Dr. Anderson recorded thirty-six years in coal mining. Miner complained of a 6 year history of shortness of breath, difficulty sleeping, and a cough. Dr. Anderson performed a chest x-ray and a PFT. He found the chest x-ray to be positive for pneumoconiosis. He listed the following under the heading of final diagnoses: (1) Category I pneumoconiosis; (2) restrictive defect due to post operative changes; (3) history of pulmonary fungus infection, treated; and (4) symptoms of arteriosclerotic heart disease.

In a one page report dated March 8, 1983, Dr. Robert W. Penman recorded that the Miner left the coal mines in July of 1982 after surgery on his right lung because of a "fungus infection." (DX 10, 30). Miner complained of shortness of breath for about 10 years, as well as occasional wheezing and coughing. He conducted a PFT and determined that Miner suffers from a

restriction of volume. Dr. Penman concluded that there is adequate history of exposure to coal mine dust and x-ray change for a diagnosis of coal worker's pneumoconiosis. He also concluded that lung function is impaired.

Dr. C. F. Arnett examined the Miner on April 23, 1983. (DX 30). Dr. Arnett recorded that the Miner last worked in the coal mines in June of 1982. Dr. Arnett conducted a chest x-ray, PFT, and an ABG. Miner complained of cough with sputum production, wheezing, dypnea, and orthopnea. He found no evidence of coal worker's pneumoconiosis. When asked whether, in his opinion, the diagnosed condition was related to dust exposure in the patient's coal mine employment, Dr. Arnett wrote "No x-ray evidence chronic pulmonary disease, normal ABG's, PFT's."

The Miner was hospitalized from January 30, 1996 to February 6, 1996, for evaluation of end-stage renal disease for possible initiation of dialysis treatment. (DX 18, 25). The discharge diagnosis by Dr. Sujatha Reddy included (1) end-stage renal disease secondary to diabetic nephropathy with small dense kidneys with nephrotic syndrome with anorexia, nausea, vomiting, weight loss, hyperkalemia, metabolic acidosis, and hyperphosphatemia improved with hemodialysis treatment; (2) anemia secondary to end-stage renal disease; (3) history of coal worker's pneumoconiosis; (4) hypertensive cardiovascular disease with concentric left ventricular hypertrophy, left atrial enlargement, mild aortic insufficiency, mitral regurgitation, normal wall motion; (5) small sores on the right little toe as well as right lower leg chronic healing without infection; (6) adult onset diabetes with retinopathy status post laser treatment with decreased vision; (7) history of nephrolithiasis in the remote past; (8) status past appendectomy, cholecystectomy, status past pancreatitis; (9) recent depression improving; and (10) ANA negative. On February 4, 1996, Dr. Corazon Chua saw the Miner for his depression. (DX 18, 25).

During a hospitalization from February 23-27, 1996, Dr. Reddy recorded that the Miner was complaining of high fever. (DX 18, 25). The discharge diagnosis after a four day hospital stay included (1) sepsis secondary to proctitis with fever, chills, leukocytosis, and malaise improved; (2) ischemic left hand with nonhealing left forearm graft wound with ischemic areas of the skin overlying the graft; (3) slight volume depletion on admission resolved; (4) secondary hyperparathyroidism on Calcijex therapy; (5) adult onset diabetes under good control; (6) end-stage renal disease secondary to diabetic nephropathy with nephrotic syndrome and chronic anemia; (7) hypertensive cardiovascular disease with concentric left ventricular hypertrophy; and (8) diabetic retinopathy and diabetic peripheral neuropathy. A history of coal worker's pneumoconiosis was recorded.

On March 14, 1996, the Miner was seen at the Middle Tennessee Medical Center, Inc., after passing out. (DX 20). Dr. William R. Huffman rendered a diagnosis of (1) syncope questionable etiology; (2) chronic renal failure; (3) dementia; (4) cervical strain; (5) contusion of the left hip; (6) diabetes mellitus; (7) mild cerebral concussion; and (8) anemia probably

secondary to chronic disease. Dr. Bradburn saw the Miner in consultation on March 15, 1996, for syncope and paranoia. (DX 20).

After a hospitalization from March 15-26, 1996, John G. Pearson recorded a discharge diagnosis which included (1) mild concussion; (2) mild dementia; (3) Meniere's disease; (3) multiple pulmonary infections, fungal; (4) history of right upper lobe lobectomy; (5) history of pancreatitis; (6) diabetes times 43 years; (7) diabetic foot ulcer; (8) history of appendectomy; (9) history of negative coronary arteriograms in 1992; (10) vascular access procedure, left upper arm brachiocephalic fistula; (11) diabetic retinopathy in both eyes having required laser photocoagulation in the past; (12) familial history of a combination of asthma and bronchiectasis in the family; and (13) end-stage renal disease secondary to diabetic nephropathy. Dr Pearson noted that the Miner's major medical problems included pulmonary fungal infections. Dr. F. Louthan saw the Miner on March 18, 1996. (DX 20). He diagnosed (1) pneumonia; (2) maxillary sinusitis; (3) lung nodule; (4) syncope per Dr. Bradburn; (5) insulin dependent diabetes mellitus; (6) chronic renal failure; (7) history of multiple pulmonary problems, including blastomycosia, cryptococcosis and coal worker's pneumoconiosis; and (8) history of positive PPD, status post prophylaxis. On March 19, 1996, Dr. W. Gross saw the Miner in consultation and diagnosed (1) maxillary sinusitis, relatively immuno-compromised patient; and (2) positional vertigo. On March 26, 1996, Dr. J. T. Carter operated on the Miner, the operation consisting of the placement of left brachial to cephalic arterial venous fistula including the secondary anastomosis to the basilic vein. (DX 20).

The Miner was hospitalized from May 6-10, 1996. (DX 20). Upon admission, Dr. Sally H. Bullock recorded that the Miner's past history included end-stage renal disease, coal worker's pneumoconiosis and a history of positive PPD with INH treatment. The discharge diagnosis by Dr. Bullock included (1) delirium; (2) end-stage renal disease; (3) mild sleep apnea; and (4) vomiting, etiology uncertain.

On May 17, 1996, the Miner underwent surgery for placement of right external jugular vein cut down perm catheter. (DX 20). After a hospitalization lasting from May 19, 1996 to May 28, 1996, Dr. Gary Patton listed a discharge diagnosis of (1) delirium; (2) dementia; (3) renal failure; (4) diabetes; and (5) history of cerebrovascular accident. (DX 19). On May 20, 1996, the Miner was seen by Dr. Lyle Myers of assistance in management of insulin-requiring diabetes. (DX 19). On July 5, 1996, the Miner underwent surgery for the insertion of a hemodialysis catheter by percutaneous technique right subclavian vein. (DX 18).

On August 30, 1996, the Miner was seen in out-patient surgery prior to amputation of his right great toe. (DX 18, 25).

The Miner was hospitalized from November 18-19, 1996. (DX 18, 25). The final discharge diagnosis by Dr. Reddy included Alzheimer's disease and Hpokalemia. Listed as "Other Significant Diagnosis" was (1) end-stage renal disease; (2) history of coal worker's

pneumoconiosis; (3) history of hypertension with hypertensive cardiovascular disease; (4) diabetic retinopathy; (5) history of prostatitis; and (6) history of diabetes mellitus.

Hospital records from the Miner's final hospitalization on December 27, 1996, are in the record, at which time he was admitted for gangrene in both feet, left foot amputation and hemodialysis. (DX 18, 25). Dr. Reddy recorded that the Miner's past medical history included chronic pleural thickening on the chest x-ray with a history of coal worker's pneumoconiosis and fungal pneumonitis. The discharge diagnosis by Dr. Reddy included (1) dry gangrene; (2) diffuse severe peripheral vascular disease; (3) chronic malnutrition; (4) adult onset diabetes mellitus with retinopathy with end-stage renal disease with peripheral neuropathy and vasculopathy; (5) hyperglycemia; (6) dementia; (7) arteriosclerotic heart disease; (8) end-stage renal disease secondary to diabetic nephropathy with chronic anemia; (9) hypertensive cardiovascular disease; (10) history of coal worker's pneumoconiosis; (11) above knee amputation of the left leg and debridement of the right foot gangrenous areas per Dr. Cook on 12/28/96; (12) postoperative metabolic encephalopathy with decreased mentation, sleepiness and sinus tachycardia; (13) progressive respiratory failure secondary to metabolic encephalopathy and hypoventilation; and (14) asystole with expiration on 01/02/97 with new inferolateral ischemia on electrocardiogram.

The death certificate lists the date of death as January 2, 1997. (DX 8). Signed by Dr. Reddy, it lists the cause of death as asystole due to infero-lateral myocardial infarction and arteriosclerotic heart disease. Listed as "Other significant conditions contributing to death but not resulting in the underlying cause given in Part I," are metabolic encephalopathy and diffuse severe vascular disease.

By letter dated January 31, 2000, Dr. John D. Rudd stated that the Miner had multiple medical problems at the time of his death, including ischemia heart disease, metabolic encephalopathy secondary to renal failure, severe vascular disease, and respiratory failure. (DX 17). Dr. Rudd stated that the Miner's "pneumoconiosis related to his work in the coal mines definitely contributed to the respiratory failure which he experienced around the time of his death and contributed directly to his death."

In a letter dated August 10, 2000, Dr. Rudd stated that the Miner had been a patient of his over the last three years of his life. (DX 26). Dr. Rudd recorded that the Miner was transferred from inside the coal mines to outside in July of 1979, secondary to x-ray changes consistent with Category I pneumoconiosis. The Miner underwent a partial lobectomy in July of 1982. Dr. Rudd concluded that the Miner "definitely suffered from his pulmonary disease and renal insufficiency secondary to the treatment of the pulmonary disease and both of these hastened his death." When specifically asked if the Miner was totally disabled due to a respiratory disease arising out of coal mine employment, Dr. Rudd responded, "Received total disability for pneumoconiosis on March 8, 1983."

Discussion

Mrs. Hopkins, the Claimant, filed her survivor's claim in 1999. Entitlement to benefits must be established under the regulatory criteria at Part 718. *See Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988).

Pneumoconiosis

Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). The regulations define pneumoconiosis as:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

Section 718.201(a). Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence.

There are numerous readings of chest x-rays taken during the Miner's hospitalizations. These readings are not classified according to the ILO Classification system, nor do they mention pneumoconiosis or fibrosis related to coal dust exposure. In *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 BLA (June 19, 1997)(en banc)(unpublished), the Board reiterated that "when an x-ray is not classified, and makes no mention of pneumoconiosis, the administrative law judge

has discretion to infer whether or not the x-ray is negative for pneumoconiosis." I find that these chest x-rays are negative for pneumoconiosis.

The record contains 10 interpretations of 5 x-rays that were interpreted for the purpose of determining the presence of absence of pneumoconiosis. I accord more weight to the readings of the physicians who are dually-qualified as "B" readers and Board-certified radiologists. *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23 1995)(unpublished); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). Dr. Penman was the only physician to interpret the x-ray dated July 12, 1973. He classified the x-ray as positive for the existence of pneumoconiosis. I find that the x-ray dated July 12, 1973, is positive. Drs. Cole and Brandon, who are both dually-qualified physicians, interpreted the x-ray dated February 7, 1983. Dr. Cole found the x-ray to be unreadable, while Dr. Brandon interpreted the x-ray as positive. Dr. Meyers also interpreted this x-ray as positive for the existence of pneumoconiosis. I find that the x-ray dated February 7, 1983, is positive. Dr. Cole interpreted a February 16, 1983, x-ray as negative, while Dr. Anderson interpreted the same x-ray as positive. I accord greater weight to the opinion of Dr. Cole based upon his credentials, and I find that the February 16, 1983, x-ray is negative. Dr. Penman interpreted an x-ray dated March 8, 1983, as positive for the existence of pneumoconiosis, while Dr. Cole found the same x-ray to be negative. I accord greater weight to the opinion of Dr. Cole based on his credentials, and I find that the March 8, 1983, x-ray is negative. Dr. Cole found the x-ray dated March 25, 1983, to be negative for the existence of pneumoconiosis. Dr. White, who is a board-certified radiologist, also found the x-ray to be negative. I accord greater weight to the opinion of Dr. Cole based on his credentials. I find that the March 25, 1983, x-ray is negative. I have determined that 3 out of the 5 x-rays are negative for the existence of pneumoconiosis. The three most recent x-rays are negative. I have determined that the x-rays taken during Miner's hospitalizations are negative. Claimant has not established the existence of pneumoconiosis by a preponderance of the x-ray evidence. Therefore, I find that Claimant has not proven the existence of pneumoconiosis under subsection (a)(4).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based upon biopsy or autopsy evidence. A biopsy of the Miner's lung produced a finding of anthracotic pigmentation. A finding of anthracotic pigmentation, by itself, is insufficient to establish the existence of pneumoconiosis." *See Hapney v. Peabody Coal Co.*, 22 BLR 1- _____ (2001)(en banc). The biopsy report does not diagnose anthracosis or anthracosilicosis. More importantly, the biopsy report does not provide the etiology of the anthracotic pigmentation. The anthracotic pigmentation must arise from coal mine employment to meet the definition of clinical pneumoconiosis. The biopsy report does not opine that the anthracotic pigmentation arose from coal mine employment. I find that the Claimant has not established the existence of pneumoconiosis under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption

of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

Dr. Penman issued a letter dated July 12, 1973. He interpreted a chest x-ray as positive for pneumoconiosis. The Sixth Circuit Court of Appeals has held that merely restating an x-ray is not a reasoned medical judgment under § 718.202(a)(4). *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Dr. Penman's letter does not constitute a reasoned medical judgement.

Dr. Meyers opined that Miner has radiographic findings compatible with CWP, and that Miner suffers from silicosis arising from his underground coal mining employment. Dr. Meyers performed a physical examination, chest x-ray, and a PFT. He considered an accurate account of Miner's coal mine employment history, as well as Miner's subjective complaints. Dr. Meyers' opinion, that Miner has radiographic findings compatible with CWP, is merely a restatement of his x-ray interpretation. This opinion cannot constitute a reasoned medical finding of the existence of pneumoconiosis under subsection (a)(4). However, Dr. Meyers also opined that Miner suffers from silicosis arising from coal mine employment is a finding of clinical pneumoconiosis. He provided clinical observations and findings, and his reasoning is supported by objective data. Dr. Meyers' opinion is well-reasoned and well-documented. I find that Dr. Meyers' opinion is entitled to probative weight.

Dr. Anderson found the existence of pneumoconiosis. He listed "Category I pneumoconiosis" under the "Final Diagnosis" section of his report. Dr. Anderson performed a physical examination, a chest x-ray, and a PFT. He also documented Miner's complaints of shortness of breath, cough, and difficulty sleeping. Dr. Anderson does not specifically provide the basis for his diagnosis of pneumoconiosis. It is not appropriate to conclude that Dr. Anderson's opinion is merely a restatement of his chest x-ray interpretation. Dr. Anderson did provide a detailed interpretation of Miner's x-ray in his report, but his diagnosis of pneumoconiosis was listed under the heading of "Final Diagnosis." His report is well-reasoned because it contained sufficient underlying documentation to support his conclusion. However, Dr. Anderson's report is not well-documented because he did not set forth the clinical facts, findings, and observations upon which he based his opinion. Dr. Anderson's opinion cannot support a finding of pneumoconiosis under subsection (a)(4).

Dr. Penman issued a report dated March 8, 1983. He conducted a physical examination, a chest x-ray, and a PFT, which revealed a volume restriction. He recorded Miner's subjective complaints. He concluded that Miner had an adequate history of exposure to coal mine dust and x-ray changes to diagnose CWP. He also concluded that Miner's lung function is impaired. Dr. Penman's opinion was more than just a restatement of his x-ray findings. His conclusion section, read as a whole, indicates that he relied upon the results of the PFT, as well as the chest x-ray and coal mine employment history. He provided clinical observations and findings, and his reasoning is supported by objective data. His opinion is well-reasoned and well-documented. I find that Dr. Penman's opinion is entitled to probative weight.

Dr. Arnett examined Miner and completed a Department of Labor medical examination form. He stated that he found no evidence of CWP. He submitted Miner to a chest x-ray, PFT, and an ABG. He recorded Miner's subjective complaints. He provided clinical observations and findings, and his reasoning is supported by objective data. Dr. Arnett's opinion is well-reasoned and well-documented. I find that Dr. Arnett's opinion is entitled to probative weight.

The record contains records from Miner's hospitalization, which contain multiple references to Miner's history of CWP. These records do not constitute reasoned medical judgments. Dr. Rudd issued letters dated January 2, 1997, and January 31, 2001. He stated that he had been Miner's treating physician and opined that Miner suffered from pneumoconiosis. He did not provide any clinical observations or findings, nor is his reasoning supported by objective data. I find that Dr. Rudd's letters do not contain reasoned medical judgments.

Drs. Meyers and Penman opined that Miner suffered from pneumoconiosis. Their opinions are entitled to probative weight. Dr. Arnett's opinion, which is also entitled to probative weight, held that there was no evidence of pneumoconiosis. The credentials of these physicians are unknown. The opinions of Drs. Meyers and Penman are sufficient to establish, by a preponderance of the evidence, that Miner suffers from pneumoconiosis. I find that Claimant has established the existence of Miner's pneumoconiosis under subsection (a)(4).

Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must also prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* I have found that Claimant has established that Miner was engaged for twenty-eight years in coal mine employment. No rebuttal evidence was presented. I find that Claimant's pneumoconiosis arose out of his coal mine employment in accordance with the rebuttable presumption set forth in § 718.203(b).

Death due to Pneumoconiosis

Claimant filed her claim on July 7, 2000. (DX 1). She has proven that Miner suffered from pneumoconiosis arising out of coal mine employment. She must now prove that Miner's death was due to pneumoconiosis in order to be entitled to benefits. An eligible survivor will be entitled to benefits if any of the following criteria are met:

1. Where competent medical evidence establishes that pneumoconiosis was the cause of the Miner's death, or

2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where death was caused by complications of pneumoconiosis, or

3. Where the presumption set forth in § 718.304 (evidence of complicated pneumoconiosis) is applicable.

20 C.F.R. § 718.205(c). Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. § 718.205(c)(5).

Dr. Reddy signed Miner's certificate of death, listing the cause of death as asystole due to infero-lateral myocardial infarction and arteriosclerotic heart disease. Dr. Reddy listed metabolic encephalopathy and diffuse vascular disease as other significant conditions contributing to death, but not resulting in the underlying cause. Dr. Reddy did not include pneumoconiosis as a cause of death.

Dr. Rudd issued to narrative opinions after Miner's death. Dr. Rudd opined in his first letter that Miner's pneumoconiosis definitely contributed to the respiratory failure that Miner experienced and that pneumoconiosis contributed directly to Miner's death. Dr. Rudd, in his second letter, opined that Miner suffered from pulmonary disease and from renal insufficiency secondary to the treatment of his pulmonary disease. He opined that Miner's pulmonary disease and renal insufficiency hastened Miner's death. Dr. Rudd did not provide any clinical

observations or findings. He did not rely upon any objective data to support his reasoning. Dr. Rudd's letters are not well-reasoned, nor are they well-documented. I find that they are entitled to little probative weight.

Claimant has not established that Miner's death was due to pneumoconiosis. The record is devoid of competent medical evidence relating the cause of Miner's death to pneumoconiosis. I find that Claimant has not established that Miner's death was due to pneumoconiosis by a preponderance of the evidence. Therefore, Claimant has failed to establish that she is entitled to benefits.

Entitlement

The Claimant, Pansy Prater Hopkins, has failed to prove that Marvin Hopkins' death was due to pneumoconiosis. Therefore, Mrs. Hopkins is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

It is, therefore, ORDERED that the survivor's claim of Pansy Prater Hopkins for benefits under the Act is hereby DENIED.

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THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. **A copy of the Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.**